DRAFT
Frequently Asked Questions (FAQs) about the ATR Program and RFA

What follow below is a series of commonly asked questions about CSAT's Access to Recovery (ATR) Program, as well as several points of clarification about the 2007 Request for Application (RFA) and how it differs from the previous RFA. Some questions/answers are repeated or adapted from the ATR FAQs currently on the SAMHSA webpage (www.atr.samhsa.gov), while others are updated or adapted from a series of FAQs asked by previous ATR applicants during pre-application meetings that were held in 2004 following the release of the 2004 RFA.

Background/Overview:

- What is Access to Recovery (ATR)?
  - *ATR is a 3 year competitive discretionary grant program funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT). ATR is a presidential initiative which provides vouchers to clients for the receipt of substance abuse clinical treatment and recovery support services. The goals of the program are to expand capacity, support client choice, and increase the array of faith-based and community based providers for clinical treatment and recovery support services.*

- When will the next set of ATR awards be made?
  - *August or September 2007.*

- What is the deadline for submitting an ATR application for 2007 awards?
  - *June 7, 2007.*

- How many awards will SAMHSA make under the second (2007) round of ATR funding?
  - *It is expected that up to $96 million will be available to fund approximately 18 new awards during the first year of the program.*

- Are existing grantees eligible to apply for the 2007 funding?
  - *Yes, current ATR grantees as well as entities meeting the eligibility criteria that have not received an ATR grant may apply. Eligibility is limited to the immediate office of the Chief Executive (e.g., Governor) in the States; Territories; District of Columbia; or the highest ranking official and/or the duly authorized official of a federally recognized American Indian/Alaska Native Tribe or Tribal Organization. The Chief Executive of the State, Territory, or District of Columbia, or the highest ranking official and/or the duly authorized official of the Tribe/Tribal Organization must sign the application.*

- *What is the definition of a tribal organization?*
  - *Tribal Organization means the recognized governing body of any American Indian/Alaska Native tribe; any legally established organization of American Indians/Alaska Natives which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of American Indians/Alaska Natives in all phases of its activities.*

- How does the 2007 ATR RFA differ from the 2004 ATR RFA?

  Applicants will find many similarities between the 2004 and 2007 ATR RFAs, but it would be prudent for prospective applicants to thoroughly review the details of the new RFA. Much of the material requested in the 2004 application process may still be applicable and responsive, but subtle revisions have been made to reflect lessons learned through the first round of ATR funding. Following are some of the more significant differences:

- ***Priority populations.*** *SAMHSA is interested in the use of voucher systems to support methamphetamine-related treatment and recovery support services and is working toward a target of $25 million per year within the ATR program for this purpose. Accordingly, States are encouraged to provide methamphetamine-related treatment and recovery support services within their proposed ATR projects. All applicants will be required to discuss the need for methamphetamine-related treatment and recovery support services in the target population/community and to indicate whether and how their proposed projects address the need for these services. Funded grantees will be required to report performance, progress and financial information both for their projects as a whole and for their methamphetamine-related activities.*

- ***GPRA.*** *ATR grant recipients under the new round of funding will be required to report GPRA data according to the general discretionary grant tool (ATR RFA 2007 Appendix I), and will have to collect data at intake/baseline, at discharge and at six months post intake/baseline. (Note: current grantees use the ATR-specific tool and are required to collect data at intake/ baseline, at 30 days post intake/ baseline, and every 60 days thereafter until the client is discharged from voucher funded services.)*

- ***Performance-based supplemental award.*** *Under Section II. (Award Information), SAMHSA/CSAT has initiated an incentive program for 2007 awardees by establishing a supplemental awards program based on performance. In Year 3 of the Round 2 ATR grant program, CSAT will review each grantee's GPRA data submissions to determine whether the grantee has met or exceeded (by 25 percent or more) its target for clients served, met or exceeded its target for 6-month follow-ups, and provided services within approved cost-bands. Grantees that have met or exceeded these performance criteria may receive a supplemental award of up to 5 percent of the requested third year funds.*

- ***Application guidance and submission process.*** *Applicants are advised to review Section IV. (Application and Submission Information) very carefully as significant changes have been made in the application process for the 2007 awards. Of particular note are the shipping instructions, revised page limitations, and the option to submit an ATR application electronically.*

- ***Proposal Evaluation Criteria.*** *Applicants are encouraged to review Section V. (Application Review Information), as the evaluation criteria in the 2007 RFA have been enhanced to emphasize that applications are reviewed for both quality of applicant responses in the grant proposal and evidence of cultural competence. The sections of the Project Narrative have been reorganized and evaluation points have been allocated differently than in the 2004 RFA.*

- Why has SAMHSA included a methamphetamine initiative within ATR?
  - *Growing awareness of the devastating impact of methamphetamine use on communities, and the serious effects of methamphetamine use on a user's physical, mental and social well-being, have prompted SAMHSA/CSAT to make a commitment to reduce methamphetamine use and work toward a target of $25 million per year within the ATR program. The ATR RFA includes an award criterion that will allow adjustment of awards based on SAMHSA's ability to reach the $25 million target.*

- How does SAMHSA expect grantees to track methamphetamine-related services?

  - *Grantees are expected to provide methamphetamine-related services within the ATR program and model. Funded grantees will be required to report performance, progress and financial information for both their projects as a whole and for their methamphetamine-related activities.*

- How can the grantee conduct client assessments?

  Client assessments. *In Section I. (Funding Opportunities Description) the 2007 RFA mentions that grantees need to ensure that each client receives an assessment for the appropriate level of services and is then provided a genuine, free, and independent choice among eligible providers, among them at least one provider to which the client has no religious objection. If the assessment is paid using ATR funds, it needs to be provided through a voucher funding mechanism. If funding other than ATR will cover the assessment cost, it does not need to be issued through vouchers. However, the assessment has to be conducted shortly prior to the ATR services provided to the client.*

- What are some challenges that new applicants should consider when designing their ATR projects?
  - *The first cohort of ATR grantees exhibited much success and experienced some challenges as well. New applicants/grantees should consider some of the same challenges, most of which pertained to implementation, listed below:*

    - ***Developing and implementing voucher management systems.*** *While it is possible to begin to implement an ATR voucher program without an automated data system, it is recommended that an automated system be put in place prior to implementation. An automated system enables tracking and monitoring in a timely fashion, supports report generation, and facilitates effective program management.*

    - ***Communicating and coordinating service provision between service entities.*** *The clinical treatment system and the recovery support services providers in several grantees' systems had not been accustomed to working with each other, and it was challenging to establish trust and teach each of these systems the language and culture of the other. With increased interaction, communication, and positive client outcomes, this challenge was surmounted over time.*

    - ***Recruitment and quality control of recovery support service providers.*** *Many recovery support services providers are faith- and community-based providers which have often had little experience working via a Federal funding mechanism. ATR grantees and SAMHSA have worked to provide training and technical assistance to assist these providers in dealing with new challenges associated with being brought into the grantees' ATR provider networks.*

    - ***Voucher management decisions.*** *Identifying optimal voucher lengths, billing timeframes, voucher inactivity parameters, and service/ funding authorizations are among the myriad decisions which need to be made about the voucher mechanism itself. Policies regarding voucher management affect the grantee's ability to manage the service expenditure rates (i.e., the burn rate of voucher funds). We anticipate providing technical assistance for this.*

    - ***Managing Expenditure Rates.*** *Controlling expenditure or "burn" rates is critical to remaining within annual appropriation of Federal funds, and ensuring that services continue through the entire grant project period. Differing rates of voucher issuance and redemption, and the varying cost of clinical treatment and recovery support services can lead to excess or depleted annual grant funds. Again, SAMHSA technical assistance will be provided.*

    - ***Developing a provider incentive program.*** *SAMHSA/CSAT suggests the incorporation of provider incentives. Several grantees found it challenging to provide provider incentives. One approach is to develop provider "report cards" to monitor and manage the provider networks. We anticipate providing technical assistance for this.*

- Will technical assistance be available to ATR Round 2 applicants?
    - *SAMHSA/CSAT will host two regional meetings to discuss the RFA and answer questions from applicants regarding the ATR program and application procedure. Meetings will be held on April 30th 2007 in Rockville, MD, and on May 2nd 2007 in Phoenix, AZ. Details on meeting registration will be forthcoming from SAMHSA. Please see Section I.2. of the 2007 RFA (Funding Opportunity Description/ Expectations) for examples of topics for which pre-application and post-award technical assistance may be available.*

- Will technical assistance be available to ATR Round 2 grantees?
    - *SAMHSA/CSAT will also make available post-award technical assistance. Examples of topics for which technical assistance may be provided include:*

        - *Developing and maintaining a voucher system*

        - *Eligibility determinations for clinical treatment and recovery support service providers and for determining which services in the continuum of recovery will be included in the voucher reimbursement system*

        - *Eligibility determinations for clients, including management of a system for assessment and service determinations*

        - *Identifying and determining eligibility of new clinical treatment and recovery support providers*

        - *Maintaining reasonable grant expenditure rates.*

    A more expanded list of potential technical assistance topics is presented in the 2007 ATR RFA on page 7.

- For project design purposes, what does SAMHSA consider to be a reasonable implementation period?
    - *SAMHSA would like to see projects up and running quickly, but there is no specific time limit. Readiness to implement the voucher system will be considered in evaluating and scoring applications, and SAMHSA will monitor project implementation after award. It is in the applicant's best interest to implement expeditiously in order to be eligible for SAMHSA's supplemental funding initiative which occurs during the third year of the grant. SAMHSA will monitor the ATR grantee's quarterly reporting to see how well the grantee is keeping to the schedule in its proposal. SAMHSA also recognizes that new grantees will take a relative long time to develop and implement the project versus existing grantees. SAMHSA will consider this factor during the review process. Technical assistance is available to help grantees identify and resolve implementation issues.*

- Will there be consideration for small-population States that submit a smaller application (less than $7 million)? How much regional priority will be given?
    - *The maximum award amount listed in the RFA is just that – a maximum award amount. SAMHSA fully expects to make awards at many different funding levels. There is not a minimum amount for the grants because SAMHSA encourages grants of all sizes with a variety of models and programs in different sections of the country.*

    - *Tribes and small states should not feel intimidated. The award criteria are not scored based on absolute size. Scale and complexity are not important; appropriateness and reasonableness are. Smaller entities will have a smaller administrative budget as well as a more limited provider group and smaller caseloads; an appropriate and reasonable administrative infrastructure for smaller entities can and should be less complicated.*

- *There is no fixed allocation of weight/points/funding for geographic distribution. However, in making decisions regarding funding, SAMHSA will consider whether funding is equitably distributed across regions of the country. This is one of several factors to be considered in making funding decisions.*

- What about states which combine with Tribes? Is that more favorable?
  - *It depends on other elements in the grant proposal. No extra points will be awarded solely for such collaboration. However, it may be an effective strategy for better meeting various RFA requirements and criteria. For example, a problem that most Tribes face is the lack of an administrative infrastructure to manage the ATR grant. This model would allow a State to act as the administrative body, and a Tribe to continue its historic role as a provider.*

- If a State would like to work in collaboration with a recognized Tribal Nation in response to this ATR grant, are there any jurisdictional limitations, such as State boundaries?
  - *SAMHSA will accept applications from a State, a Territory, a State or a territory combined with a tribe(s), or tribal consortiums. Collaborative applications must decide who will be the project director responsible for the ATR project management. Implementation areas for these grants must be limited to a geographic area which is within State, Territory, Tribal, or combined borders. The grantee must have jurisdiction over the proposed implementation area.*

- Could an agency apply for $7 million and be awarded less than their proposal budget?
  - *Yes. Funding decisions depend on a variety of factors, including the strengths and weaknesses of the application, availability of funds, equitable distribution in terms of geography, balance among target populations and program size, and ability to reach the $25 million target for methamphetamine-related treatment and recovery support services. It is possible that a grantee's award will be less than the proposed budget.*

Financial Aspects:

- How much funding may each grantee receive?
  - *Each grantee may request up to, but no more than $7 million in total costs (direct and indirect) per year in any year of the grant project. Based on past experience, it is expected that grant awards will range from $1 - $7 million per year. Grants will be awarded for a period of up to 3 years. Award amounts may be adjusted based on the number of clients proposed to be served per year and SAMHSA's ability to reach the $25 million target for methamphetamine-related treatment and recovery support services. The actual award amount in any one year will depend on the availability of funds.*

- What costs are classified as administrative costs?
  - *A list of services considered to be administrative costs is contained in Appendix B of the 2007 RFA. Generally speaking, expenses paid through a voucher are 'services' and any other costs are 'administration'. If they are contracted out or delivered with grantee staff, they would be administration. Administrative services focus primarily on managerial responsibilities for the ATR program, including marketing, provider eligibility determinations, quality assurance and improvement, financial management, and program monitoring activities. The direct and indirect costs of administration of the program are to include the management of information systems for tracking outcomes and costs, including the cost of data collection and reporting. These are to be held to as low a percentage of the total grant expenditures as possible, as described below.*

- Could certain costs be characterized as administrative costs in the initial stages and become part of a voucher payment as the program implemented? If we are going to expand opportunities for non-traditional providers to come into the program, they may not have the capacity to provide services without payment up front to sustain the staff they need to become involved with this program.
    - *Applicants should be careful about identifying an administrative expense initially that would be shifted into a voucher cost later in the project. SAMHSA may or may not accept such a proposal. If the applicant needs to do this to get through the startup phase, SAMHSA needs a clear justification in the application, and SAMHSA will work with the applicant.*

- What percentage of funds can grantees use to pay for the administrative costs of managing the program?
    - *New grantees may use no more than 15 percent of the total grant expenditures over the three-year grant period to cover the costs of administration. However, the percentage for the first year may exceed 15 percent to cover startup expenditures for such activities as establishing new voucher systems, provider networks, and State standards for recovery support services, as long as a 15 percent average is maintained over the life of the grant.*

    - *Current ATR grantees with established voucher and administrative systems are expected to demonstrate improved efficiencies over the course of the grant. Current ATR grantees proposing to continue services in the same geographic areas and/or populations should set a target for administrative costs of 10% of the total grant expenditures annually. The percentage of administrative costs for current grantees that successfully compete for a new award will be negotiated between 10-15%, depending on the justification and rationale for exceeding the 10% target for administrative expenses.*

- Can ATR funds be used to supplant existing funds?
    - *ATR is designed to supplement existing programs. Supplantation is not permissible under the program.*

- What is the difference between supplanting and supplementing?
    - *The definition of "supplement" is to add to or augment something that currently exists, while "supplant" is defined as taking the place of something. In the context of ATR and substance abuse treatment services, supplementation means that a grantee uses ATR funds to **complement**, **add to**, or **extend** services or programs currently in existence at the State level which already attempt to address treatment gaps. Supplantation in this context, on the other hand, would mean that a grantee uses ATR funds to **take the place of** or **replace** services or programs that currently exist in the substance abuse treatment system or related systems.*

    - *ATR funds expended are not to be used to take the place of any existing funding that currently exists for any purposes. Furthermore, ATR resources cannot be used to fund any existing levels of service, including Federal, State or local funding.*

    - *Numerous statutes require funding, grants, services, and/or programs to supplement, not supplant, existing functions. This language can be found in the Business and Professionals Code (i.e. sections 19605.7, 19610.2), the Education Code (i.e. sections 8483.7, 11021(f), 44774), the Government Code (i.e. sections 8846, 30062), the Health and Safety Code (i.e. sections 11970(e), 53275(4)), the Penal Code (i.e. section 6045.5), the Public Resources Code (i.e.25449), the Revenue and Taxation Code (i.e. section 7286.59, 18743), and the Welfare Institutions Code (i.e. section 749.23).*

    - *For more information please refer to the Attorney General's Statement on Supplementation verses Supplantation.*

http://www.healthychild.ucla.edu/FIRST5LATA/Conferences/materials/advisoryopinion.pdf

- If someone with a drug issue also has a mental health problem, can the voucher help with the mental health treatment?
  - *ATR can support co-occurring substance abuse and mental health services, but not mental health services alone. The RFA allows the flexibility to address a variety of areas where substance abuse clients may need help.*

- If a client has vouchers, can a grantee continue to bill for Medicaid and third party reimbursement?
  - *The purpose of ATR is to expand your capacity to provide services to your clients. If you are billing for Medicaid and third party, you must continue to do so.*

- *Can ATR funds be used to pay the State portion of the match for Medicaid reimbursement for clinical treatment and/or recovery support services?*
  - *This is not permissible under the ATR program. However, ATR funds could be used, for example, to pay for recovery support services that are not covered by Medicaid.*

- *How do grantees set rates for recovery support services?*

  SAMHSA suggests that applicants refer to RFA Appendix A: Comprehensive Array of Clinical Treatment and Recovery Support Services for details.

- Are the rates listed in Appendices A (Recovery Support Services) and H (Clinical Treatment) required for each applicant?
  - *The figures in Appendices A and H are per-person ranges CSAT considers reasonable, based on current data. The applicant must state what they plan to pay per-person for each service, regardless of whether a range for a service is published in either Appendix A or Appendix H or not. If costs deviate from Appendices A and H, the grantee must explain why. If there is no rate in Appendices A or H for a service to be offered, SAMHSA will give the applicant more latitude to identify a new rate, but there must still be an explanation also how the rate was determined.*

Choice:

- How will grantees be expected to assure client choice under this program?
  - *Grantees will be expected to assure client choice for their clients through maintaining a diverse network of secular and faith-based providers that offer clinical treatment services, recovery support services, or both. Grantees should keep their provider lists updated and maintain a client-friendly information system as well. If it is determined that a client is in need of and eligible for ATR services, he/she is presented with a choice of at least two providers, at least one to which the client has no religious obligation. The client makes the final determination as to which provider he/she will visit. Most grantees confirm the choice in writing and include the client's signature.*

- Does a grantee have to provide clients with a choice of assessment locations?
  - *The grantee does not have to provide a choice of assessment providers and/or locations. However, grantees need to ensure that each client receives an assessment for the appropriate level of services and is then provided a genuine, free, and independent choice among eligible providers, among them at least one provider to which the client has no religious objection. The assessor must also ensure that the*

individual is fully conversant with all of the therapeutic alternatives available from eligible providers.

Providers:

- Is there a standard set of eligibility criteria for providers to participate in ATR?
  - *No. Each ATR grantee determines the eligibility criteria for providers to participate.*

- Does SAMHSA require that the clinical treatment and recovery support service providers funded through ATR be licensed or certified?

  In the ATR program, States are responsible for establishing standards for participating providers. To be eligible for voucher reimbursement, clinical treatment and recovery support programs should meet standards that are required by the State for other providers that provide the same type of services (e.g. residential, outpatient, family support services, etc.). The services covered by ATR include clinical treatment services (which typically require licensure, certification or other credentials) as well as recovery support services which often do not require such credentialing. SAMHSA anticipates that standards for many ATR services will already have been established by the State. States may consider flexible approaches to licensure/credentialing in order to increase participation of providers and increase access to services. For services for which no standards currently exist, the State must ensure that individuals receive appropriate services in safe settings from appropriate individuals. Appendix C to the RFA describes the standards for the ATR program.

- In this RFA, does the concept of free and genuine choice and having an alternative provider apply to every covered service?
  - *The RFA clearly states that a minimum amount of choice must be offered for each ATR service. However, SAMHSA did not dictate which services must be paid with ATR funds. A grant applicant can decide which services they choose to include in the ATR program, and they may choose not to include a type of service if they can find only one provider.*

- How can treatment in rural and remote areas be expanded when there may be only one current provider? What are the requirements for a client to have a choice of providers?
  - *To ensure genuine, free, and independent client choice for substance abuse clinical treatment and recovery support services appropriate to the level of care needed by the client, the RFA requires that a client is able to choose from among two or more providers qualified to render the services needed by the client, among them at least one provider to which the client has no religious objection. SAMHSA recognizes that identifying two providers in a rural area may be a challenge; applicants who plan to serve rural and remote areas should explain the situation in the application. Grantees may plan to recruit new providers to become available in those areas during the 3-year grant period.*

  - *The ATR assessment can be used to refer a client to non-ATR services as well as ATR services. Only the ATR-paid services need to meet the choice requirement. The grantee may use non-ATR funds for services where only one provider can be identified, and ATR funds for services where there are enough providers to meet the choice requirements.*

  - *Another possibility for a State grantee is to offer ATR in an urban area and shift block grant funds from the urban area to rural areas so capacity is increased statewide. As long as the funds are shifted geographically within the State, and not moved to an activity other than substance abuse services, no supplantation will have occurred.*

- Does the assessment process have to be separate and distinct from the treatment process?
  - *It is not necessary to have separate providers perform the assessments, as long as they are making independent judgments and offering clients a fair and independent choice of treatment providers. If the grantee has treatment service providers doing*

assessments, the application will need to address how the grantee will deal with conflicts of interest.

- Is there a set of criteria or definition for a faith-based provider?
  - *The RFA does not define faith-based providers. Applicants have the discretion to establish their own criteria. However, Appendix A (Comprehensive Array of Clinical Treatment and Recovery Support Services) provides a definition of spiritual and faith-based support. Faith-based or community-based providers may be involved in a wide variety of treatment and recovery support services.*

- How do you address the issue of bringing in new community- and faith-based organizations with the types of requirements and standards that are required by the RFA?
  - *It may require additional outreach and training to bring in new community- and faith-based organizations. SAMHSA has and will provide training and technical assistance that grantees can access at any point in time to assist in increasing the number of community- and faith-based organizations in their programs.*

  - *The major requirement is that a grantee may only provide a service under this initiative that is in some way regulated through an eligibility process. The RFA requires that grantees establish eligibility standards for providers and a process for determining whether provider candidates meet those standards. Clinical treatment and recovery support programs should meet standards that are required by the State for other providers that provide the same type of services (e.g., residential, outpatient, family support services, transportation, etc.). Grantees have choices regarding the methods for determining and documenting provider qualification - licensure, standards, certification, etc.*

  - *There are basic safety requirements that SAMHSA would expect a grantee to apply to any service under this initiative. Beyond those safety issues, applicants have the flexibility to start year one of ATR services with a basic method of determining eligibility and transition into licensure and more demanding standards over the life of the grant. See Appendix C (Standards for the Access to Recovery (ATR) Program).*

- What strategies can be used to assist faith-based organizations meet eligibility requirements with regard to becoming ATR providers?
  - *The RFA allows the grantee to provide faith-based organizations with the resources and opportunities to meet standards for high quality care. For example, individuals or agencies that want to become eligible as an ATR provider could be provided training on how to meet health and safety codes. Another strategy might be to facilitate mentoring exchanges between already qualified agencies and faith-based organizations.*

  - *Since the State will establish standards for providers in the ATR program, another strategy might be to allow a phase-in period for more difficult or costly requirements and not require meeting full eligibility requirements immediately for certain types of providers. However, the State must ensure that services are provided in safe settings from appropriate professionals, and the State must monitor compliance with established standards and/or processes.*

- Which are fundable services for the faith community and which are not?
  - *This is an issue that each grantee has to work out, within its own legal and practical parameters. ATR makes no distinction between faith-based and non-faith based providers. Faith-based providers can provide any ATR service. Grantees can require faith based providers to follow their own established eligibility standards, or extend a concept adopted in one State and adopt equivalent standards that accommodate the unique needs of faith-based providers without affecting quality of care.*

- How can incentives be built into a voucher program?
    - *Experience with performance based contracting is helpful in developing an incentive program. Incentive programs can be implemented by adjusting provider eligibility reimbursement based on certain performance outcomes. The incentives may either be in the form of a 'reward' or 'penalty,' based on evidence of outcomes. Funding of an incentive program typically is through a separate funding set-aside for distribution upon evidence of outstanding performance or through agreement with the participating providers to reimburse initial service provision at a percent of the fee-for-service rate, such as 90 percent. The balance of the reimbursement rate (e.g., 10 percent) that is withheld and set aside will be used to encourage positive client outcomes and reimburse high performing providers according to an established protocol. In the latter example, providers with exceptional performance will receive an 'incentive' bonus while those that are not demonstrating positive outcomes will not receive the full reimbursement rate. You may want to include provider representatives in developing an incentive program.*

    - *Incentive programs can also be established to induce individuals to participate in a required data collection interview, but the RFA limits the awarded incentive to no more than $20 or equivalent (coupons, bus tokens, gifts, child care, and vouchers). Incentives may not be used to motivate clients to enter services (see Section IV.4 Funding Limitations/Restrictions in the RFA).*

Services:

- What kinds of services are applicants/new grantees expected to provide through ATR?
    - *SAMHSA expects applicants to design a program that offers a range of clinical treatment and recovery support services. Clinical treatment includes such services as screening/assessment, brief intervention, treatment planning, individual counseling, group counseling, and pharmacological interventions. Recovery support services are intended to support people seeking to live free of alcohol and drugs, and include such services as employment services and job training, transportation, case management, after care, educational services, life skills, spiritual and faith-based support, and peer-to-peer services. For a more expanded list of services offered under the program please refer to Appendix A of the RFA (Comprehensive Array of Clinical Treatment and Recovery Support Services).*

- Some programs refuse to take government funds, such as 12-step programs. What are effective ways of accessing those services, apart from faith-based services?
    - *Following consultation with the self-help community in developing the 2004 ATR RFA, an episode of care was carefully defined as a "paid service." A 12-step meeting would not be a reimbursable ATR service in itself, but you might consider vouchers for transportation or child care services that could be used to facilitate attendance at these meetings.*

- Are applicants prohibited from putting a total number of units of certain designated services on the voucher instead of a total dollar amount?
    - *The RFA does not specify what must be on a voucher or what cannot appear. Grantees should design vouchers to suit their needs for managing their ATR program.*

    - *Grantees have many options regarding voucher use. One option would be to put the rates for each service and the maximum units of service allowed onto the voucher. For example, a voucher could authorize up to 60 hours of outpatient treatment at $50 per hour resulting in a total amount not to exceed $3000. Or a different approach may be that the rates do not appear on the voucher itself, just the Not To Exceed amount. The rate-per-unit for each service is then put in the agreements previously made with each provider, and those rates are set for as long as that provider agreement is in force.*

Data:

- How willing would current grantees be to share their Management Information Systems (MIS) and source codes for the program with other States?
  - *Many of the current ATR grantees have developed data systems with Federal and local funding and these are in the public domain. If more information is needed regarding current ATR data systems, please request technical assistance from SAMHSA in this area.*

- What data will grantees submit to the Federal government as part of the grant?
  - *Grantees must first submit information on the number of types of providers for both clinical treatment and recovery support services. These will include secular and faith-based providers both enrolled in the ATR system and redeeming ATR vouchers.*

  - *Grantees will be required to report performance in several areas relating to client substance use, family and living conditions, employment status, social connectedness, access to treatment, retention in treatment and criminal justice status. Grantees will be required to collect this data using the General Discretionary Grant Tool which is Appendix I in the RFA.*

  - *There are two other tools grantees are responsible to report to CSAT: the voucher information tool to report the amount for which a voucher was issued, and a voucher transaction tool that is used to report the amount for which a specific provider redeemed the voucher. These tools are used primarily for tracking the status of each voucher that is issued to an ATR client. These tools are provided in Appendices J and K in the RFA.*

  - *Funded grantees will be required to report performance, progress and financial information both for their projects as a whole and for their methamphetamine-related activities.*

  - *Grantees must submit required financial information and information not included in GPRA data on a monthly basis. The GPRA data will be submitted on an ongoing basis. Additionally, grantees are responsible for quarterly progress reporting to SAMHSA Grants Management.*

  - *The monthly progress reports must include the performance data described in Section I-2.1 of this announcement, as well as information about fraud and abuse monitoring and examples of client success, until the grantee develops the capability to upload data through CSAT's GPRA Data Entry and Reporting System (www.samhsa-gpra.samhsa.gov). After that time, the monthly progress reports will include only the performance information not captured in the GPRA Data Entry and Reporting System (e.g., information about fraud and abuse monitoring and examples of client success).*

- How often are grantees required to collect GPRA data using the General Discretionary Grant Tool?
  - *GPRA data must be collected in a face-to-face interview at baseline (i.e., the client's entry into the project), at discharge, (or exit from ATR services), and at six months post baseline. Grantees will be required to obtain a minimum 80 percent six-month follow-up rate.*

- How are grantees expected to collect data for individuals moving through multiple levels of care?
  - *Grantees should plan data collection the way that works best for them. While data on outcome domains must be collected by providers, the RFA does not require that every provider collect such data. One provider could collect the outcomes on behalf of other providers that are not equipped to collect outcome data.*

- How often are grantees required to submit GPRA data to SAMHSA?
  - *Data must be entered into the GPRA Data Entry and Reporting System (www.samhsa-gpra.samhsa.gov) within 7 business days of the interview forms (intake and discharge) or transaction forms being completed. Grantees are expected to take action necessary to ensure data are valid and reliable, and are submitted in a timely manner. Data reporting is required to commence upon admission of the first client.*

- Are grantees required to make any other submissions to SAMHSA?
  - *Grantees are required to submit on a quarterly basis an ATR report that covers programmatic, management, and fiscal information as well as other pertinent topics. Additionally, the grantees are required to submit a Performance Assessment Annual Report.*

- Does the voucher system have to meet the requirements of the Health Insurance Portability and Accountability Act (HIPAA)? Is there a code for nontraditional treatments, such as spiritual support?
  - *Yes. While the grantee is not a covered entity, all providers will have to be HIPAA-compliant. It would be cost effective for the grantee to accept HIPAA-compliant transactions.*

- How will SAMHSA award supplemental funds based on performance?

  - *In Section VI-2 of the RFA, Administrative and National Policy Requirements discusses a grantee's proposed performance targets and explains that failure to meet stated goals and objectives may result in suspension or termination of the grant award, or in the reduction or withholding of continuation awards. Conversely, an ATR grantee that exceeds its performance targets or demonstrates efficiencies may receive a supplemental award based on performance to maintain its high level of performance.*

    Under Section II, Award Information, the RFA states that the amount to be awarded for continuation awards in year 3 is expected to be 95% of the amount available awarded for continuation awards in year 2. This is being done to create a pool of funds for supplemental performance based awards (described below). [Note: Applicants should not reduce their requested third year amounts relative to year 2; this adjustment will be made by SAMHSA at the time the year 3 continuation awards are negotiated.]

    For year 3 of the ATR grant program, CSAT will review each grantee's Government Performance and Results Act (GPRA) data submissions and assess whether a grantee has: 1) met or exceeded its target for the number of clients served by 25 percent or more, 2) met or exceeded its target for 6-month follow-ups[1], and 3) provided services within approved cost-bands. Any grantee that has demonstrated appropriate financial management of the grant and has exceeded its targets for the number of clients served by 25 percent or more, exceeded its target for 6-month follow-ups, and provided services within allowable cost bands, may receive a supplemental award of up to 5 percent of the third year requested amount based on performance. Supplemental award amounts will be determined on a sliding scale based on availability of funds and the grantee's achievement of performance goals and demonstration of sound fiscal management. Applicants should be aware that SAMHSA/CSAT does not plan to make supplemental awards to all grantees, and that it is possible that no grantees will receive supplemental awards based on performance.

    Eligible grantees will be asked to submit a narrative and budget justification for the supplemental award that maintains the increase in its targets during the final year of the project. The supplemental award based on performance is for the purpose of the

[1] The follow-up rate must be at least 80 percent of the number of clients actually served.

grantee maintaining, at a minimum, the additional number of clients for the remainder the project. A grantee receiving a supplemental award based on performance may be subject to additional site visits and/or audits to verify the accuracy of the client data reported.